FIS 0284 (11/02) Office of Financial & Insurance Services

Clean Claim Report

You may file this report for an individual claim if it is a payable clean claim.
It must be a claim filed with a Health Care Plan for a covered service.

If claim meets each of these conditions, continue.
If claim does not meet each condition, you may not file this report.

Provider Tax ID number (FEIN)	

Provider's Plan ID Number	
Member's ID number (Not member's Medicaid ID)	
Procedure Code	
ICD-9-CM Diagnosis Code	
Authorization No. (if required for particular service)	

Provider Name

Provider Address

City **State** **Zip**

Health Care Plan Name

Member Name

Important Note: Format all dates as MM/DD/YY

Date of Service	**Date Provider billed Plan**

1. Did Provider have proper plan authorization (including authorization number) at the time of service, if required? ☐ Yes ☐ No ☐ NA

2. Did Provider use a clearinghouse to check for completeness of claim form? ☐ Yes ☐ No

3. Did Provider verify plan membership of patient at time of service? ☐ Yes ☐ No

4. Did Provider verify Primary Care Provider (PCP) status at the time of service if required? ☐ Yes ☐ No ☐ NA

5. Did Health Care Plan communicate any denial of your request for payment? *If Yes, skip 5A. If No, complete 5A and skip to 7.* ☐ Yes ☐ No

5A. *If Health Care Plan did not respond to the request for payment,* describe *any proof you have that they received the claim:*

6. Reason given by Health Care Plan for denial of payment: *Explain in words. Do not use Plan rejection codes!*

6A. Date of 1st denial by plan

7. Was a second denial received? ☐ Yes ☐ No

7A. If yes, was corrected information given? ☐ Yes ☐ No

7C. Date 2nd claim submitted

7B. Reason given by *Health Care Plan* for 2nd denial of payment:

7D. Date of 2nd denial by plan

8. Have you discussed this claim with Health Care Plan staff? ☐ Yes ☐ No

8A. If Yes, what was the Plan's explanation (if any) for the claim rejection?

9. Did you send a copy of this report to the Health Care Plan? ☐ Yes ☐ No

If Yes, complete **9A**. If No, your clean claim report processing will be delayed.

9A. Date of notification

Certification: I certify that this information is complete and correct. I have followed the requirements of Public Act 316 of 2002. This claim is a payable clean claim that met all required timelines for claims submission under the act.

Signature of Provider or represenative	Date signed	Signer's name and title typed or printed

Attach any additional information that provides facts or proof that will assist us in settlement of this claim. Any such attachments are subject to the above certification of Provider or representative.

PA 316 of 2002 as amended requires submission of this form by any provider seeking relief for clean claims not paid in a timely manner as described in the act.